

醫藥警備



**MEDIK
AWAS**

A Community Service
Organised by the:



**SINGAPORE
MEDICAL
ASSOCIATION**

For Doctors, For Patients

MEDIK AWAS CARD FOR DRUG ALLERGIES/MEDICAL CONDITIONS

APPLICATION & REGISTRATION FORM

GST Reg. No. M0-0000156-C

INSTRUCTIONS:

1. Please type or use **BLOCK** letters when completing this form.
2. Section A & B **MUST** be completed and signed by a Medical or Dental Practitioner.
3. Patient's personal particulars & Next-of-kin's particulars **MUST** be completed.
4. The patient is to **sign and mail** to: **Singapore Medical Association, 166 Bukit Merah Central #04-3531 Eagles Center, Singapore 150166** or email (**scanned documents**) to: **medik@sma.org.sg**
 - the completed form, duly signed by the doctor and patient
 - payment by PayNow or Bank Transfer (Please do not send Cash or Cheque)
 - two recent Passport sized photographs (Color or Black & White)
5. The Medik Awas card will be mailed to the patient within 4 to 6 weeks of application.
6. For enquiries, please call 6223 1264

PERSONAL PARTICULARS (to be completed by Patient)

PATIENT:

Name: _____
 Address: _____
 _____ S ()
 NRIC No.: _____
 Telephone: _____
 Date of Birth: _____ Sex: _____
 Ethnic Group: _____ Blood Group: _____

NEXT-OF-KIN (spouse, child, relatives, etc.):

Name: _____
 Address: _____
 _____ S ()
 Telephone: _____
 Relationship to Patient: _____

SECTION A – DRUG ALLERGIES (to be completed by Doctor ONLY)

The information entered in this section will be edited for inclusion on the identification card. Please fill in clearly and accurately. Please provide both Trade and Generic names of the drug(s).

Drugs Suspected (Specify trade name)	Daily Dose & Route	Date Begun	Date Stopped	Reason For Use
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Concurrent Medication (Drugs given at the same time but not responsible for the reaction):

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

DESCRIBE REACTION:

	Yes	No
(a) Anaphylactic Shock	<input type="checkbox"/>	<input type="checkbox"/>
(b) Eyes Puffy	<input type="checkbox"/>	<input type="checkbox"/>
Lips-swollen	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of tongue	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing (Rhonchi)	<input type="checkbox"/>	<input type="checkbox"/>
Hypotension	<input type="checkbox"/>	<input type="checkbox"/>

(c) Skin – Rash: Generalised
 Localised Specify: _____
Rash: Urticaria Non urticaria
 Pruritus Yes No
Mucosa Lesion: Oral Yes No

(d) Other adverse reactions : Describe _____

(e) Onset: Gradual Sudden Unknown
Requires hospitalisation: Yes No

Source of Information: Observed by reporting doctor
 Past event recounted by patient/relative
 Past event reported by another doctor
 Others (specify) _____

SECTION B – MEDICAL CONDITIONS (to be completed by Doctor ONLY)

Eg. Bleeding tendency/diabetes or long term medications such as steroids or anticoagulants. This information will be displayed on patient’s card/amulet.

DOCTOR’S DECLARATION

The facts as stated are to my knowledge correct and I have no objection to my name and telephone number being included on the identification card.

Doctor’s Full Name (Print): _____

Hospital / Clinic: _____

Ward: _____

Address: _____

Telephone: _____ MCR No.: _____

Doctor’s Signature / Stamp
Date:

PATIENT’S DECLARATION

I *have/have not applied for MEDIK AWAS Card previously. (If yes, my File No. is _____)

I agree to this record being place with the MEDIK AWAS Committee of the Singapore Medical Association and that they and/or their Agents and the members of its staff will not be responsible in any way whatsoever in the event of my sustaining any loss, damage or injury whatsoever by reason of their wrongful act, neglect or omission.

I paid \$ _____ via #PAYNOW (UEN No. S61SS0168E), #BANK TRANSFER SMA DBS Account No: 001-063564-6 for

registration and identification card (\$30)

registration, identification card and amulet (\$40). Limited to 3 drug allergies only.

renewal of identification card or amulet (\$15). Eg. change of address, loss of item or addition of new information)

(All fees are inclusive of GST)

#Please indicate your full name as in NRIC as your reference so we can trace your payment and attach the payment screenshot.

Date: _____ Patient’s Signature: _____

<p>PLEASE NOTE: After reviewing the application, the physician or patient may be contacted for further clarification by one of the physicians in the Medik Awas Committee.</p>	<p>For Official Use</p> <p>Receipt No.: _____ Receipt Date: _____ File No.: _____</p>
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